

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS644HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2009
NAME OF PROVIDER OR SUPPLIER HORIZON SPECIALTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 640 DESERT LANE LAS VEGAS, NV 89106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 21994</p> <p>This Statement of Deficiencies was generated as a result of a State licensure focus survey and complaint investigation conducted in your facility on 11/4/09 and finalized on 11/5/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>Complaint #NV00022895 was unsubstantiated. Complaint #NV00023038 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000		
S 340 SS=F	<p>NAC 449.363 Personel Policies</p> <p>5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC.</p> <p>This Regulation is not met as evidenced by: Surveyor: 21994</p>	S 340		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS644HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2009
NAME OF PROVIDER OR SUPPLIER HORIZON SPECIALTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 640 DESERT LANE LAS VEGAS, NV 89106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 340	Continued From page 1 Based on interview and record review the facility failed to ensure 8 of 10 employee health records contained documented evidence of tuberculosis screening in accordance with NAC 441A. (Employees #3, #4, #5, #6, #7, #8, #9, and #10) Severity: 2 Scope: 3	S 340		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.